BULLETIN

AMERICAN COLLEGE OF SURGEONS

August 2002
Volume 87, Number 8

Licensed to heal



The ethical duties of a surgeon

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About the cover...

In his article "Licensed to Heal" (p. 8), Michael D. Dent, DMin, reminds surgeons that "physicians do not have a license to kill, thrill, deal, or steal, but to heal." He also offers five suggested means for ensuring that surgeons provide competent and compassionate care to their patients.

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From my perspective



The surgical practice environment is a dynamic one subject to ongoing change. New pressures and expectations continually arise. At times it may appear that achieving the reforms necessary to meet these fluctuating demands and to resolve inherent problems is a slow and frustrating process. However, when one considers the various forces and factors at play, the ability of organized medicine, specifically the American College of Surgeons, to respond to and influence the waves of the future is really quite remarkable.

As part of the College's ongoing reorganization, we have altered our committee structure so that we can more effectively deal with pressing issues, including graduate medical education, surgical competence, diversity in the workforce, enhanced appeal to young surgeons, and advocacy and health policy. Following is a summary of how we are changing our committee structure so that we can address the issues of today.

"We have altered our committee structure so that we can more effectively deal with pressing issues, including graduate medical education, surgical competence, diversity in the workforce, enhanced appeal to young surgeons, and advocacy and health policy."

Graduate surgical education

Early last month, the Accreditation Council for Graduate Medical Education (ACGME) presented the final report from its panel on resident work hours and the learning environment. The document was developed over a lengthy period of time with input from multiple organizations, including the College. If the proposal is adopted, it will lead to significant changes in the way in which surgical residents are trained, including the number of hours they are expected to work. Also, the work environment in hospitals will have to change. For example, training institutions will need to hire additional support staff to augment the coverage deficit that is likely to occur given the shorter work hours.

All of us who have a stake in surgical training will need to band together to gain an understanding of how these new rules should be implemented. To that end, the College hosted a meeting last month that allowed representatives from all the surgical specialties to discuss their plans for complying with the proposed changes. It is clear to many of us that if the profession fails to improve resident work hours and the training environment, the government will take legislative and regulatory action, which inevitably will lead to more bureaucratic nightmares for the profession. Clearly medicine, and specifically surgery (because it is likely to be more affected by these changes than are other disciplines), needs to come together and reconsider the way we have trained residents up to this point.

The College's new committee structure will allow us to more effectively respond to an array of educational issues, including those brought forth by the ACGME. Through our Division of Education, we are establishing an oversight committee of surgical educators who represent the broad spectrum of specialties. This committee will supervise and coordinate the activities of three subcommittees, which will focus on the following issues: medical student education, resident education, and continuing surgical education. We intend to recruit the best volunteer educators to help us

examine these three areas and to help us make the surgical training process more rewarding and more effective. I believe these committees can be very helpful in increasing interest in a surgical career among medical students and in making the education process more fulfilling by offering not only scientific programs but courses in ethics and practice management as well.

Also on the medical student education front, through our Subcommittee on Medical Student Education we plan to formulate a strategy for introducing medical students to the spectrum of surgical specialties and demonstrating the range of career options and expectations associated with each of the disciplines.

Competence

Just as we need to fulfill the needs of medical students and surgical residents, we will always need to provide opportunities for practicing surgeons to improve and refine their skills through continuing medical education (CME). To that end, we have established three workgroups charged with helping the College develop programs to promote core competencies. Specifically, the three panels are expected to generate programs centered on interpersonal and communications skills, systems-based management, and practice-based learning. We anticipate that these workgroups will create a curriculum that we can incorporate into our CME programming.

In addition, other committees that are working with the Division of Education will also have close ties with the Committee on Emerging Surgical Technology and Education and with a newly constructed Committee on Perioperative Care. All of these bodies will be encouraged to engage in cooperative efforts to develop courses, Clinical Congress sessions, and so on, in order to meet the needs of surgeons at all levels of training.

Diversity

All surgeons need to be aware of the demographic changes that are taking place within the surgical workforce, and the College must be willing to meet the needs of individuals who in the past may not have chosen a career in surgery. For example, in an effort to encourage more women to get involved in the College and to enter the surgical disciplines, the College formed a Committee on Women's Issues some time ago. We are also working in close collaboration with the Association of Women Surgeons (AWS) on issues of concern to women surgeons.

In addition, we recently created a new Committee on Diversity, which will study the educational and professional needs of underrepresented surgeons, so that they are supported and encouraged by the policies of the ACS. I am pleased to announce that Myriam Curet, MD, FACS, a general surgeon from Stanford, CA, and the current president of the AWS, will be the first chair of this important committee.

Advocacy and health policy

A 2001 survey of College Fellows indicated that surgeons are almost unanimous in their desire to have the College become their aggressive socioeconomic advocate.* I believe that we can satisfy this expectation and become a more forceful agent for the profession with regard to reimbursement, professional liability, and other issues of great concern to surgeons.

To help the College and its Fellows manage the effects of government policies on the health care arena, we formed the Health Policy Steering Committee, which is composed of surgeons representing all specialties and who have expertise in political and socioeconomic issues.

Additionally, as I noted in my April 2002 column, we have a new component of the College, the American College of Surgeons Professional Association, which has 501(c)6 tax status. The American College of Surgeons Professional Association was first proposed by the Governors' Committee on Socioeconomic Issues. This new branch of the College has allowed us to form a political action committee comprising surgeons from various specialties who have a particular interest and acumen in political activity.

These committees, supported by a restructured Division of Advocacy and Health Policy, should do much to promote the College's ability to act as a true advocate for practicing surgeons. We anticipate that the new structure will allow us to be more effective with regard to federal and state legisla-

*Knight TT, Richardson JD, Kalbfleisch JH: Career disaffection among surgeons in the era of managed care. *Am Surg,* 68:519-523, June 2002.

tive and regulatory affairs, assisting Fellows with practice management, communication with policymakers, and outreach to the public.

Young surgeons

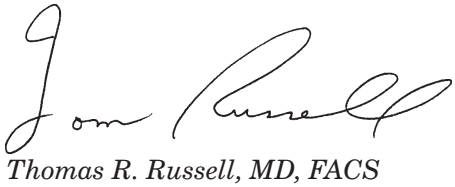
Because the future of our profession and this organization is dependent on young surgeons, we established the Candidate and Associate Society of the ACS a few years ago. This group has been working to introduce residents to the mission and vision of the College and to foster an ongoing relationship with them throughout the early phases of their careers. The work of the CAS replicates that of the College's Committee on Young Surgeons (CYS), which for many years has endeavored to introduce young Fellows who are new to practice to the various programs and activities of the College. The activities conducted by the CYS continue to be of fundamental importance to the work of the College, and the group serves as an important conduit between young Fellows in practice and ACS leaders.

Finally, through our new Subcommittee on Medical Student Education, we are currently in the process of formulating plans to set up a mechanism for interacting more closely with medical students. We believe it is important for medical students to become affiliated with the College very early on in their careers so that they can be introduced to the entire spectrum of surgical care and its various disciplines and gain an in-depth understanding of the benefits and challenges a career in surgery would offer them.

Across-the-board cooperation

As the College's new and restructured committees work on these issues, they and the College as a whole are increasingly collaborating with other surgical and medical organizations and forming issue-related coalitions. I believe these cooperative efforts will become even more important in the coming years, providing organized medicine with a united voice. As one significant step toward coalition building, the College continues to have active dialogue with the American Medical Association and to work in a cooperative spirit with the AMA and other organizations who share our vision.

Because the health care waters will continue to be less than tranquil, the committees I have discussed in this column, as well as others not mentioned here, will need to be reorganized to ensure that we have a dynamic group of volunteers who understand the changing issues. We will also need to ensure that surgeons who serve on these panels are dedicated to creating an environment that will best allow our Fellows to deliver surgical care of the highest quality to their patients. These individuals must also remain devoted to changing the way in which our profession is perceived, so that we can continue to attract the best medical students and residents into the fold.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

CMS proposes changes for 2003 fee schedule

On June 27, the Centers for Medicare & Medicaid Services (CMS) announced proposed changes to the Medicare physician fee schedule for 2003. By far the most important change would involve recalculating the Medicare Economic Index (MEI)—one of the key elements used in determining the annual update to the fee schedule conversion factor. CMS proposes to revise and decrease the "productivity adjustment" that is applied to the MEI, a suggestion that the College and other specialty organizations have long advocated. Using the old productivity adjustment, the annual update under current law is projected to be minus 5.5 percent next year. The proposed revisions would result in an update of minus 4.4 percent instead.

Unfortunately, the proposed rule did not contain revisions to the data or methodology involved in calculating malpractice relative values. It was hoped that meaningful changes would be proposed in order to more fairly compensate specialists experiencing rapidly escalating malpractice premiums at the same time that their overall payments continue to decline.

House acts on Medicare payment proposal

Early in the morning of June 28, the House of Representatives adopted H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002, by a vote largely along party lines of 221 to 208. This bill includes provisions that would address flaws in the current fee schedule update system, which threaten to slash physician reimbursement by an additional 15 to 20 percent over the next four years.

As a result of this proposed provision, the conversion factor will increase by 2 percent in 2003, as opposed to the 4.4 percent decrease estimated in the fee schedule proposed rule recently issued by CMS. Updates of roughly the same amount would also be granted in 2004 and 2005.

There is broad support in Congress for addressing the Medicare physician payment issue, but it is not at all clear whether an agreement will ultimately be reached on a new prescription drug benefit. If agreement cannot be reached on prescription drugs and other larger issues, the physician payment relief provisions must be incorporated into another bill that is destined to pass.

ACS comments on proposed EMTALA revisions

On May 9, CMS issued a proposed rule on the hospital prospective payment system that includes provisions that would ease burdens imposed on surgeons and other physicians by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. Subsequently, the agency issued two program memoranda answering some of the most frequently asked questions about hospital responsibilities under EMTALA, including on-call issues.

On July 8, the College submitted comments in response to the proposed rule, detailing surgery's concerns about the on-call issues and touching on other provisions of the CMS proposal that would affect

surgeons and their patients. More specifically, the College's letter states the following:

- CMS should state explicitly that hospitals are prohibited from requiring physicians to be on continuous call.
- The College supports CMS's change of policy that will allow on-call physicians to provide simultaneous coverage at several hospitals.
- CMS should clarify that on-call physicians should not be required to respond to emergent cases or to perform procedures for which they do not hold hospital privileges.
- CMS should clarify that physicians are allowed to perform elective services at their own discretion while on call.
- CMS should establish a clear policy stating that once patients are admitted to the hospital on an inpatient basis, EMTALA no longer applies.
- The College supports the revision of CMS policy on the applicability of EMTALA to off-campus hospital departments and the clarification that it does not apply to on-campus provider-based entities.
- CMS should clarify that the movement of a patient with an emergency medical condition from the main hospital building to another on-campus entity does not constitute a "transfer" if done in order to provide that patient with an EMTALA-mandated service.

More than 40 Fellows submitted individual comments on the EMTALA rule in response to an alert published in the College's weekly electronic newsletter, *NewsScope*. The full text of the College's comments may be viewed on the Web site, at *http://www.facs.org/dept/hpa/views/emtala.html#1*.

Liability reform efforts continue in Congress

The College continues to encourage congressional passage of medical liability reform. Earlier this year, the College announced its support for the HEALTH Act of 2002 (H.R. 4600), which was introduced by Rep. Jim Greenwood (R-PA). This legislation is modeled after medical liability reform laws passed in California in the 1970s.

The House Judiciary Subcommittee on Commercial and Administrative Law held a June hearing on health care litigation reform to explore whether limitless litigation restricts access to health care. The College submitted testimony to the committee that focused on the problems surgeons are facing with increased liability insurance costs. The House Energy and Commerce Committee is scheduled to hold hearings on the liability crisis in July.

Sen. John Ensign (R-NV) has announced plans to introduce the HEALTH Act in the Senate once he finds appropriate cosponsors. Surgeons are urged to go to the ACS Legislative Action Center *(http://capwiz.com/facs/issues/bills/?bill=152865)* to send letters to their senators and representatives asking for their support of the HEALTH Act.

Licensed to heal



by Michael D. Dent, DMin, Tyler, TX

Editor's note: *This article is an adaptation of an ethics address delivered to the 169th semiannual scientific meeting of the Texas Surgical Society in April 2002 in Tyler, TX.*

The weekly worship services of the downtown congregation that I pastor are televised and broadcast by radio to a large part of northeast Texas. Sometimes not everybody agrees with what I say.

As the chair of the ethics committee at a large, not-for-profit hospital, I am aware that some surgeons may choose to disagree with some of the reflections that follow as well. My goals in this article are to encourage reflection on the ethical dimensions of surgical practice, to affirm what is taking place already, and to share some reminders rooted in ethics that are fundamental and helpful in daily practice.

R. Scott Jones, MD, FACS, declared in the epilogue of his Presidential Address during the American College of Surgeons' Convocation last October in New Orleans, LA, "To function effectively in the health care system…to navigate in a trillion dollar industry, we need a compass: medical ethics."[1] That last word is a needed reminder of what Paul Ebert, MD, FACS, wrote in the first sentence in his foreword to the most comprehensive work in the field, *Surgical Ethics:* "The surgical profession…has always had a profound concern for the ethical practice of medicine as essential to the quality of care it provides."[2]

Ethics of licensure

In most states one must obtain a license to hunt, fish, drive, cut hair, serve liquor, or carry out at least a dozen other activities. Physicians must not only earn degrees, pass exams, and pay fees, they must also be granted a license to practice medicine and earn certification to perform surgery. From an ethical standpoint, the licensure to practice medicine is also one to heal. Physicians do not have a license to kill, thrill, deal, or steal, but to heal. To heal means to make whole, to restore to soundness.

From an ethical context come five basic principles to assist a surgeon in fulfilling that internal call and external empowerment to heal, to care for, and to serve competently and compassionately. These standards follow.

1. *Patients are primary.*

The passage of the Patient Self-Determination Act by the U.S. Congress in 1991 formally legislated a patient's autonomy and the right to make decisions about his or her health care. That shift in decision-making authority from the physician to the patient had been in process for several decades.

While this shift perhaps threatens some physicians, it actually represents a return to a fundamental focus in medical practice: the centrality of the patient. Dr. Ebert notes, "The American College of Surgeons believes that the ethical practice of surgery promotes an environment in which all patients are treated with dignity, tolerance, and respect for their wishes. Surgeons accepting Fellowship in the College are asked to place the welfare and rights of their patients above their own, and to treat each patient as they would wish to be treated, were they to become patients themselves."[2] That approach to the physician-patient relationship echoes the ancient standard of human interaction found in one form or another in practically every major world faith community and known most commonly as the Golden Rule: "Do unto others as you would have them do unto you."

How does one make his or her surgical practice more patient-centered? Let me suggest several ways: Take time to communicate with patients. Listen to them. Get to know them. Learn about their fears and their families.

In March, I conducted a funeral for a beloved parishioner. The granddaughter of the deceased is a third-year student at a prominent medical school in a major metropolitan area. She makes rounds with physicians in the hospital. I asked her what she would say to a group of surgeons. She had two responses: "Take a few moments to listen to your patients. Second, explain to them their medical condition in terms they understand." This student told me she occasionally goes back to patients' rooms to clarify what the physician told them. A physician who takes the time to listen and makes the effort to communicate clearly will be one who experiences high levels of trust on the part of those he or she serves.

A related essential element is caring follow-up with the patient and family following an op-

eration. As a pastor for almost 30 years, I have heard surgeons deliver bad news in a good way and good news in a bad way. Certainly, honesty and confidentiality are prominent ethical concerns, but *how* one delivers a surgical outcome can be as important as the actual outcome.

A few months ago, I experienced a colonoscopy, for which I was anesthetized. I remember nothing of the procedure. What I do remember is the phone call from the physician's office the next day checking to see if I was okay. He did not have to have his office staff call and check on me, but the concern he demonstrated made me feel better emotionally.

Patients are primary. The surgeon's first ethical responsibility is to promote and protect his or her patients' interests, well-being, and dignity, and to be their fiduciary.

2. *All surgeons are ethicists.*

Ethical decisions are unavoidable in surgery. Almost daily, surgeons are confronted with choices about sometimes competing and conflicting ethical issues, including confidentiality, costs, honesty, conflicts of interest, and patient autonomy. Ethics is the disciplined study of morality and raises such questions as "What ought morality to be? What ought character to be? What ought conduct to be?"

In the initial chapter of *Surgical Ethics,* "Principles and Practice of Surgical Ethics," the trio of authors sets the tone for the book, saying of a surgeon, "The goal is to follow one's reasons…where they lead. In this way, one submits one's thought processes to the intellectual discipline of ethics and thus achieves an intellectually disciplined study of what the morality of surgeons ought to be."[2]

Ethics can and does sometimes exist without a religious framework, but often the two are directly connected. While a surgeon must respect the patient's beliefs and values, it is also true that "surgeons possess as much of a moral right to their own moral and religious integrity as do patients."[2] Furthermore, "Surgeons must be clear about their moral and religious commitments, as well as the price of moral and religious integrity."[2]

Perhaps the most frequent ethical challenge surgeons face is conflict of interest. While believing the patient is primary, other loyalties regularly stake their claims. The demands of self-interest, insurers, hospitals, employers, managed care organizations, and the government all leave one asking, "For whom does the surgeon work?"

Because it is impossible to eliminate ethical conflicts of interests—as the Bible says of the poor, "they are always with you"—one must sometimes look beyond oneself for guidance in ethical decision making and conflict resolution. Competence in clinical ethics is dependent on a sound method of ethical analysis and on familiarity with the literature in the field of medical ethics. But there is another readily available, often underutilized resource to which surgeons can turn for assistance in their roles as ethicists.

3. *Employ ethics committees.*

Almost every hospital of any size has an ethics committee. One of the primary functions of the committee is being available for consultation on an as-needed basis. Most committees have one or more physician/surgeon member(s). Four serve on the committee I chair.

The purpose of an ethics committee is broader than acting as a consultant when moral dilemmas arise, however. Surgeons also may work with such committees to develop policies that ensure that patients are "treated in a medically and morally appropriate fashion."[2] The committee further serves to educate the hospital staff and general community in medical ethics and the issues involved.

If an ethics committee is unavailable or ineffective, one may turn to a professional ethics consultant. Mark Siegler, MD, coauthor of the widely used *Clinical Ethics,* spoke earlier this year to the medical staff of a Tyler hospital. He is professor of medicine and director of the MacLean Center for Clinical Medical Ethics at the University of Chicago, IL. Dr. Siegler and his staff have conducted 2,000 consultations in the last 20 years. They now perform an average of three a week.

So, help is available when a surgeon faces an ethical conflict. Such support might emanate from a book, an ethics committee, or an out-of-town con-

sultant. Taking the time and effort to secure ethical assistance in difficult cases is a caring, compassionate, and sensitive act that will contribute to improved patient health care delivery.

4. *Practice self-care.*

The proverb, "Physician, heal thyself" is at least as old as the first century CE, ascribed to Jesus of Nazareth in the gospel compiled by Luke, a physician himself. Biblical scholars say an equivalent of that well-known maxim appears in every age and language.

The parallel between physician and pastor is a close one, as both are helping professions filled with individuals who are dedicated to caring for others, putting patients or parishioners first, while often neglecting to care for themselves and sometimes their families.

The high incidence of suicide, alcohol and drug abuse, and marital failure among physicians is distressing to all. Along with many recently highly publicized cases of unethical sexual misconduct by members of the clergy, the medical profession in my state has had its share of problems. In January, a leading Texas newspaper did a series of front-page stories on physicians' immoral and/or illegal behavior. The paper reported the state board of medical examiners investigated 1,328 physicians in Texas in 2001; 19 had their license to practice medicine revoked, 300 were put on probation, and 609 remain under investigation.

These numbers could be reduced with additional attention to self-care. Days off, vacations, sabbaticals, and a reduced workload renew one physically and emotionally. One stressed-out person asked, "How can I be good for everybody else if I am not good for me?"

Impairment is more than being a victim of drug or alcohol abuse—it can result from a mental or physical illness or injury. It is possible to harm oneself while constantly helping others. If a physician has a colleague who is on the road to self-destruction, he or she has an ethical obligation to intervene and assist in restoring that impaired physician to health and to practice if possible. Aiding professional colleagues is a part of being "licensed to heal" as well.

"There is a sacred dimension to what physicians are licensed to do, an awesome power to restore people to life."

5. *There is a spiritual value in the healing hands of a surgeon.*

There is a sacred dimension to what physicians are licensed to do, an awesome power to restore people to life. There is more to the practice of surgery than meets the eye. The current patient is more than a physiological process in room 258, bed two. He or she is a human being, a person with physical, emotional, intellectual, and spiritual dimensions.

As the authors of *Clinical Ethics* note, "Concentration on the physiological components of pain through pharmacological or surgical interventions, without equal attention to the psychological, social, and spiritual, may bring little relief." They add, "Physicians should make themselves aware of these components and seek assistance from those expert in dealing with them. The presence of religious counselors is often of immeasurable value to the patient, to the family and to the physician."[3]

Two different people have asked me the same question in the past month: "Have you ever heard of a doctor praying with the patient before surgery?" The inquirers were surprised that a surgeon would do such a thing. There are some ethical issues in that practice of prayer. Is it offered as an option to the patient? Is it directed at persons of no faith or a faith different than the physician's? Is it a person in power taking advantage of a person who is vulnerable? Such prayer could be very appropriate or tremendously inappropriate, depending on the answers to these types of questions. Nonetheless, there is something special, sacred, and spiritual about the process of surgery, something that is inexplicable—not magical, but certainly mysterious.

In a chapter with the intriguing title, "The Snake and the Saints," Albert R. Jonsen, PhD, writes:

> We frequently hear that physicians "play God" when they make decisions about life and death. The phrase is supposed to suggest arrogance. Yet it is a dim echo of the ancient beliefs that in all healing, God is active. The rabbis of ancient Judaism justified the use of physicians by proposing that they healed by the power of God. Ambroise Paré, the father of modern surgery…adopted the motto, "I treat, God heals." In a more secular era, the flippant phrase "playing God" is about all that remains of that ancient belief. Yet with it we remind ourselves of the mystery of medicine.[4]

Call it an awesome ambiguity or a miraculous mystery, surgeons represent the source of beneficence, healing, and hope in the eyes of many they treat. Patients entrust their lives to finite and fallible physicians with the expectation to be treated with care, competence, and compassion.

Here is an example of how surgery is perceived as a divine act, a sacred task. It was presented by a member of the church that I pastor. This 72-year-old man was recently hospitalized for seven weeks—in and out of the surgical intensive care unit following several delicate surgeries and two weeks in rehab. These are the first words he penned to his pastors on a thank you card: "People pray for miracles and God sends his doctors to perform them."

Hands are holy. Surgery is sacramental. Medicine is miraculous for many on the receiving end. They see the good done as a gracious reflection of Providence.

A time to heal

In a day when not only medicine but the world is evolving rapidly in ways often beyond our control or liking, medical ethics provides surgeons and other health care givers a guide to stay the course. Such a compass in our post-September 11 culture will keep those licensed to heal focused on the beneficent values of comfort over disease, peace over war, wholeness over brokenness, and compassion over anything else. Ω

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Program shows medical students *the human side of surgery*



by Karen M. Sandrick,
Chicago, IL

The typical medical school experience does not expose students to clinical medicine, especially not to clinical surgery, until their third-year clerkship rotations. So medical students often are first introduced to direct patient care through residents who are hard-pressed to finish their own surgical cases and research projects, let alone guide medical students in the development of the physician-patient relationship, school students in the delivery of compassionate care, or help fledgling physicians to confront anxieties about the day-to-day practice of surgery.

The human element

But medical students at Washington University, St. Louis, MO, have the opportunity to be thrust into patient care situations in their first year. Sandwiched between their anatomy and physiology sessions, first-year students may hear a woman explain how she reacted to the news that she had advanced breast cancer and wrestled with each of her treatment options. The students may listen to an African-American senior surgeon describe what it has been like not only to treat minority patients but to be a minority surgeon within an academic medical system. The first-years may learn from clergymen about patients who agonize that their illnesses are punishments from God.

In the process, students not only get a respite from the basic science that dominates their medical school days, they also get an idea of what to expect when they one day will step onto the wards. "You start thinking how you should go about interacting with patients and their families, dealing with issues such as death and dying and recognizing how people's perspectives change as they grow older and their perceptions that the quality of life matters more than the length that is left," medical student Rob Ridenour said.

Students also are learning to recognize the importance of making emotional connections with patients. "You have so much you can do for patients. You can give hope to patients you could never give hope to before. But even with all this technology, sometimes there is nothing you can do for a patient," Mr. Ridenour said. "You have to be able to relate to that person on a different level, to try to help them emotionally with their disease rather than physically."

Further, the students are building a sense of self. "A lot of us are wondering, 'Am I going to be a good doctor? Am I going to be able to do this well?' and all that goes into that, especially with the decision making that doctors inevitably have to do in the face of uncertainty. We are realizing that our first job is to know who we are and where we stand on issues before we can help our patients," another student, Virginia Pierce, said.

Unique course work

Mr. Ridenour and Ms. Pierce are two of 20 medical students who this year participated in the Topics in Medicine elective course, Dealing with Sick Folks and Their Families, at Washington University—which, somewhat surprisingly, is directed by a surgeon, Ira J. Kodner, MD, FACS, professor of surgery. As Dr. Kodner explains, medical school courses that explore relationships with patients, compassionate care, diversity, medical teamwork, religious and spiritual values, and clinical decision making usually are controlled by internists or other primary care physicians.

This situation is not rooted in surgeons being remote from patient care issues. On the contrary. Surgeons—particularly those like Dr. Kodner, a colorectal cancer surgeon—must, on a daily basis, deliver bad news, address ethical and religious concerns, decide what is best and most cost-effective for a patient, and clearly explain treatment options and alternative choices. "No one except surgeons takes on the responsibility of meeting someone, getting to know them and their families within a short period of time, cutting them open, and doing some threatening thing to their bodies. Dealing with life-and-death cancer surgery or issues of body image or the risk of complications from surgery is part of our lives," Dr. Kodner said.

Surgeons nevertheless are not generally involved in Topics in Medicine-type courses early in a medical student education because of the present-day realities of academic surgery. For one thing, there is little time for surgeons to spend with medical students. Teaching also is costly because it takes surgeons out of the operating suite, Dr. Kodner said.

That means, however, that medical students do not see surgeons in action until they move onto harried surgical services, where they see patients at most the night before the operation or see surgeons only in the operating suite. "In the OR, they see us cut people open and hold retractors, hear us answer a few questions about the specific disease and operation, and that's usually it," he said.

But, as Dr. Kodner stresses, "No one but a surgeon goes to bed at night knowing they have to wake up the next morning and do something that's potentially threatening to another being. We don't take that responsibility lightly, but we haven't taken the time to put it into words and especially to disseminate it to medical students. Medical students don't get to see us in that phase of our function as compassionate role models."

Dr. Kodner decided to try to change the perception of surgeons 10 years ago by developing the

Dealing with Sick Folks course with the help of Mary Gilley, RN, an operating room nurse who manages and coordinates the care of patients in the colorectal surgery service. "Because of the nature of the educational process, students just haven't had the chance to watch someone through role-model situations deal effectively with patients and their families and manage the stress that goes along with illness and surgery and the interruption of life," Ms. Gilley said.

Keeping it real

Dealing with Sick Folks has become a popular elective, attracting about a fifth of all first-year medical students. Over the course of six sessions, Dr. Kodner and Ms. Gilley introduce students to the basic principles of becoming a compassionate physician. Frank Richards, MD, clinical instructor in the department of surgery at the university's school of medicine, explores dealing with individual sensitivities associated with different cultures, ethnicities, and races as well as certain types of patients, such as the obese. Virginia Hermann, MD, FACS, professor of surgery in the university's department of general surgery and clinical director of the breast surgery service, discusses telling the truth and breaking bad news to patients. A group of health care professionals address the complexities of working as a clinical team. Rabbi Mark Shook and Chaplain Janet Crane examine religious and spiritual aspects of medical care. A cancer survivor and Ms. Gilley talk about decision making from the patient's perspective.

Dr. Kodner and Ms. Gilley gather background material from their individual practice experience, including journal papers from the nursing, social services, and medical literature as well as articles in the popular press and videotapes of motion pictures and television series. Then they leave the actual classroom work to the students, who lead group analysis of the literature, direct discussion of issues raised by guest speakers, quiz classmates, raise ethical situations, and participate in role-playing.

The dynamic produces some memorable experiences. Dr. Kodner recalls the time that an elderly man who was dying of lung cancer and his wife told each other things they had never spoken of before when interviewed by a senior internist in front of the students. As Dr. Kodner was walking the couple to their car after the class, the man told him, "'You know, I thought I was going to die, but I'm not. I'm going to live on in these doctors.'"

For the students, the Dealing with Sick Folks course offers a glimpse into the process of actually taking care of patients, not just the science behind it. "The course is not the glycolysis pathway or the anatomy of the pelvis; it makes medicine more real for us," Ms. Pierce said.

The course also provides a mechanism for students to start assessing their own emotional capabilities. "The issue of drawing the line so students can protect their own emotional integrity and still be compassionate physicians is one of the more complex things we deal with in every single class, to the point of tears, because some students are stressed by how much of themselves they will be giving to each of their patients," Dr. Kodner said.

Ms. Pierce feels the course is opening the door to further personal exploration. "In large part, because we're kept so busy with all the other studying we need to do for exams, we felt we didn't have a forum or the time or we are in some way apprehensive to discuss some of these issues with each other. But now we feel we can continue to talk with one another as we progress through our education and not let some of these issues fly by as we're trying to become technically proficient or fill our brains with biochemical pathways," she said.

The course also has increased students' awareness of the roles that surgeons play. "The surgeon sees patients during a time that is in many cases very emotionally charged and in some cases life-changing. Surgeons help patients make major decisions and get patients through critical time periods. Surgeons also maintain ongoing relationships with patients. Although surgeons may not know patients very well before they are referred for surgery, their relationship can become very strong in the acute period and continue over time. You would expect a family physician or internal medicine doctor to be dealing with patients and their families, but the surgeon lends a unique and valuable perspective, " Ms. Pierce said. Ω

Additional information regarding the course, Dealing with Sick Folks and Their Families, may be obtained by contacting Ira J. Kodner, MD, FACS, tel. 314/454-7204; e-mail IJKodner@aol.com.

Ms. Sandrick *is a medical writer in Chicago, IL.*

Selecting the best MEDICARE PAYMENT OPTION

by BARBARA CEBUHAR, Communications Specialist, Division of Advocacy and Health Policy, Washington, DC

For most surgeons, Medicare reimbursement has steadily declined for more than a decade due to congressional action, payment policies developed by the Centers for Medicare & Medicaid Services (CMS, formerly known as the Health Care Financing Administration), and technical factors associated with the resource-based relative value scale (RBRVS) system. Surgeons have been vocal in expressing their concerns about how these payment cuts affect the viability of their practices and their ability to serve Medicare patients now and in the future. The College has had some success in increasing the values assigned to the work component of many services, but those improvements have been mitigated by reductions in reimbursement for practice expenses and in the Medicare conversion factor.

While there are ongoing efforts to persuade Congress and CMS that system-wide changes are needed, surgeons do have limited choices with regard to the nature of the financial relationship with the Medicare program and the patients it serves. They may choose to be either participating or nonparticipating physicians, or they may choose to opt out of the program altogether. There are benefits and drawbacks to each of these options, however, which surgeons may not understand sufficiently to make truly informed decisions. It is important to recognize that CMS publishes two Medicare fee schedules (MFSs), one for participating physicians (100% of MFS) and one for nonparticipating physicians (95% of MFS).

In general, three Medicare payment options are available to physicians:

1. Participating physicians with assignment.
2. Nonparticipating physicians with assignment.
3. Nonparticipating physicians without assignment.

Additionally, a physician may opt out of Medicare completely and work as a private contractor (see table below).

Participating physician option

Most physicians, particularly surgeons, have signed agreements with Medicare to serve as participating physicians. "Pars" agree to take assignment on all Medicare claims and to accept the program's approved reimbursement amount as payment in full for all covered services provided in the coming calendar year.

Every November, physicians receive a Medicare participating physician/supplier agreement (CMS 460) and a copy of the Medicare fee schedule for the next year. Those who are currently participating in the program *do not need* to take any action to maintain their status; it is automatically renewed for the coming year unless they make a change.

One of the principal advantages to participation is that the allowed reimbursement rate is 5 percent higher than the amounts paid in a separate MFS for nonparticipating physicians. Pars also follow more simplified billing procedures. Partici-

Payment options

Payment arrangement	Payment	Remittance	Example: Medicare allowable: $100
Participating physician	100% MFS	80% carrier direct to MD; 20% from patient, or secondary insurance (Medigap)	$80 remitted from carrier; $20 remitted from patient or secondary insurance (Medigap)
Nonpar + assignment	95% MFS	80% carrier direct to MD; 20% from patient, or secondary insurance (Medigap)	$76 remitted from Medicare carrier; $19 remitted from patient or secondary insurance
Nonpar w/o assignment	Limiting charge: 115% of nonpar MFS (109.25% of par FS)	Remitted from patient to MD	$109.25 remitted from patient
Private contracting	Negotiated with patient after completing opt-out procedure	Direct from patient to MD	No Medicare payment allowed except in emergency; rate negotiable with patient

pating physicians accept assignment and the local carrier makes payment of 80 percent of the allowed amount directly to the physician. They need only to collect the 20 percent copayment and any deductible from the patient or Medigap payor. Another significant advantage is that the par claims are reimbursed more quickly. In addition:

- Participating physicians are listed in Medicare directories that are distributed to many seniors' groups and, in many cases, are available on the Internet.
- Local carriers provide physician offices with a toll-free claims transmission service and send claims directly to many Medigap insurers.

Nonparticipating physician option

Electing to be a nonparticipating physician further restricts the "allowable" charges when compared to participating physicians.

Nonparticipating physicians assume a higher level of risk and effort to collect their fees. Nonparticipating physicians *who do not accept assignment* may seek limited balance billing of up to 115 percent of the nonparticipating Medicare rate. Surgeons who choose this option must notify their local Medicare carriers of their intent to become nonparticipating physicians by letter with a postmark no later than December 31 of each year. "Nonpar" agreements remain in force for a single calendar year. Current nonparticipating physicians do not need to submit any additional paperwork.

Nonpars may bill in two ways. They may still *take assignment,* but the allowed amount will be 5 percent less than the full Medicare fee schedule payment. Once a physician agrees to take assignment for a claim, it cannot be revoked. The physician must collect any deductible and the 20 percent coinsurance from the patient, but the Medicare payment is made directly to the physician. Again, the total collected from Medicare, the patient, and any coinsurance amounts to only 95 percent of the full fee schedule payment allowed for participating physicians.

Physicians *who do not take assignment* (that is, they select "No" in Section 27 of CMS 1500 or the electronic claim form) may balance bill up to 115 percent of the nonparticipating allowed amount (95% of the fee schedule amount). In other words, unassigned claims may total 115 percent of an amount equal to 95 percent of the Medicare fee schedule amount—for a total of 109.25 percent of the participating Medicare fee schedule. For example, insertion of a chest tube is reimbursed by the Medicare fee schedule at $184. Balance billing would allow a surgeon to charge $201.02 ($184 x 1.0925).

Physicians must file unassigned claims, but the patient receives the check from Medicare. The physician must then bill the patient directly for the services up to the limiting charge.

Some Medigap plans will cover the difference between the allowable charge and the limiting charge for nonparticipating providers. Surgeons may wish to contact the plans in their local area to determine which programs offer this coverage.

They also may want to consider the following practice management factors:

- Other contractual agreements (hospital privileges, insurance, or state regulations) that stipulate that Medicare assignment must be taken.
- Costs, patient mix, and collections rate to determine if the total amount from balance billing would exceed revenues that have normally been received as a participating physician. According to the AMA's *Medicare RBRVS: The Physicians' Guide,* the average physician would need to collect the full limiting charges (109.25%) at least 35 percent of the time to make balance billing viable for their practice.
- Medicare *only* routes assignment claims to the Medigap insurer. For unassigned claims, physicians must file with the Medigap insurer directly.
- Certain services are only paid on an assigned basis: (1) physician services to patients eligible for both Medicare and Medicaid; and (2) services provided by a nurse practitioner, physician's assistant, certified registered nurse anesthetist, midwife, clinical social worker, clinical psychologist, or clinical nurse specialist.

Private contracting

A private contract is one between a Medicare beneficiary and a physician or practitioner who has formally agreed to not bill the program *at all* for two years—for all covered items or services furnished to Medicare beneficiaries. These contracts must meet specific requirements.

To opt out, a physician must sign and file an af-

fidavit with the usual local carriers, agreeing to forego payments from Medicare for two years. This abstention applies both to direct Medicare payments and to those made through a Medicare managed care organization. The affidavit must be filed at least 30 days before the quarter in which the contract is to become effective (that is, 30 days prior to February 28, May 31, August 31, and November 30). There is a 90-day period during which a physician may change his or her mind and revert to a participating or nonparticipating arrangement. Surgeons exploring this option should check their other contracting relationships (hospital privileges, other insurers, and so forth) to determine if any of these contracts require them to be Medicare providers.

The patient, through a signed and explicit contract with the physician, gives up his or her benefits under Medicare and agrees to pay the opt-out physician directly for all items or services provided without regard to any limits (such as limiting charges). The document must demonstrate that the beneficiary has no access to Medigap insurance, will not bill Medicare or ask the physician to bill Medicare, and state that he or she had an opportunity to select another Medicare provider but chose this physician instead. There are a number of other elements that need to be included in this contract. Consult your local carrier to ensure this contract has all the required components. Copies of the patient contracts should be maintained in the physician's office.

In an emergency situation, a physician who has opted out of the program may treat a Medicare patient, file a claim, and balance bill. The emergency-related treatment should be fully documented on the patient's chart and in the supporting billing documents.

State law complications

Before considering any of the alternatives to full Medicare participation, it is important to note that many states have enacted more restrictive legislation. Following are some examples of state laws that affect Medicare payment.

Minnesota physicians treating Minnesota residents are precluded from balance billing any amount. The state does not, however, formally require participation in Medicare, although the balance billing prohibition is a powerful incentive for many physicians to continue participation.

Some states, including **Pennsylvania** and **Vermont** (33 VSA, Section 652), prohibit balance billing. This, in effect, means that participating physicians will receive the approved Medicare rate, while nonparticipating physicians will receive 95 percent of the allowed rate.

According to the Medical Association of **Georgia,** many of the state's private insurance plan contracts now prohibit balance billing. Therefore, balance billing is an offense sanctionable by the state medical board and it is actionable as an unfair business transaction under Georgia law.

It is also important to note that state laws may apply further limits to balance-billing charges. For example, revisions to **New York's** balance-billing law, effective August 29, 1994, reduce the amount a physician may bill a Medicare beneficiary to 105 percent of the Medicare-approved amount (105% of 95% for nonparticipating physicians is 99.75% of the participating rate). This law does not apply to CPT codes 99201-99215 for routine office visits, and codes 99341-99353 for routine home visits. Surgeons who would like more information should contact the New York State Department of Health at 518/478-1141 or refer to the following fact sheet: *http://www.ghimedicare.com/provider/download/ghipar02.pdf.*

Check with your local carriers for information about variations in state law that may reduce or eliminate entirely the financial benefits of balance billing and private contracting. Ω

Author's note: This article is not meant to provide legal or practice advice, but attempts to suggest that there are options available to surgeons. We have identified several state situations of which we are aware, but this is by no means a definitive listing. Before deciding which approach to take, we suggest that you consult your usual local carriers, state medical societies, your practice manager, or attorney. Questions may be directed to bcebuhar@facs.org.

This document contains excerpts from the AMA-published *Medicare RBRVS: The Physician's Guide,* 2002. For more information, go to *www.ama-assn.org/ama/pub/article/1751-5756.html.*

In compliance...

...with HIPAA rules

by the Division of Advocacy and Health Policy

Previously in this series, the College suggested that it would be a good idea to have your practice appoint a privacy officer to oversee all activities that ensure the privacy of the information contained in your patients' records. This month's column focuses on the various tasks for which a privacy officer is likely to be responsible.

Responsibilities to the office

The privacy officer's primary job will be to drive the development and implementation of policies and procedures that comply with the Health Insurance Portability and Accountability Act (HIPAA). This responsibility may involve consulting with your practice's legal counsel to ensure that the policies and tools you use comply with both federal and state privacy laws. The privacy officer will initiate any privacy risk assessments in the practice and perform ongoing compliance activities. This task includes creating and maintaining any forms and patient notices that are legally required.

The privacy officer also will be responsible for establishing protocols for accessing confidential information, which means ensuring that each staff member has access only to the information needed to perform his or her specific job. It also includes determining which staff members need access to specific information, in which format, and creating a process that grants the right to access the specific information. The privacy officer needs to work with all personnel involved with any aspect of release of protected health information to ensure full coordination and cooperation within your practice. The practice also will have to implement a mechanism to track access to confidential health information.

Every practice will have to assemble a policy manual that contains all the privacy and confidentiality policies, forms, and procedures governing the practice. The privacy officer will have to be involved in the maintenance of that manual. HIPAA also requires that every practice conduct privacy policy training for all employees, and the privacy officer will be responsible for developing those training sessions and documenting that the training has been provided.

Responsibilities to patients

The privacy officer also is responsible for the oversight of patients' access to their medical records. HIPAA provides that patients have the right to inspect and amend the records your practice maintains on your encounters with them. If a patient has a problem with your privacy policies, the privacy officer will need to establish and administer the process to receive, document, track, investigate, and take action on those complaints.

Continuous coordination within your practice and the cooperation of all members of your practice will ensure that your privacy officer is able to establish a secure privacy system that will comply with HIPAA requirements. Ω

ACS guidance on HIPAA issues is based on information contained in the "Small Practice Implementation Guide" version 1.2 *(http://snip.wedi.org/public/articles/index.cfm?Cat=17),* © 2001, The Workgroup on Electronic Data Interchange.

Keeping current

What's new in *ACS Surgery: Principles and Practice*

by Erin Michael Kelly, New York, NY

Following are highlights of recent additions to the online version of *ACS Surgery: Principles and Practice,* the practicing surgeon's first and only Web-based and continually updated surgical reference. A sample chapter and detailed information on *ACS Surgery,* including how to save $20 on a subscription to the online version, is available by visiting *www.acssurgery.com/learnmore.htm*.

IV. Preoperative Preparation

Outpatient Surgery. Richard B. Reiling, MD, FACS, and Daniel P. McKellar, MD, FACS. Safe and cost-effective elective surgery begins with a carefully charted history, a thorough physical examination, well-chosen laboratory tests, and consultation as appropriate. It then proceeds to selection of the optimal procedure, assessment of patient suitability, and choice of the most appropriate site in which to perform the procedure, such as an office surgical facility, an in-hospital day surgical unit, and so on. In their new chapter, Drs. Reiling and McKellar address these issues as they pertain to outpatient surgery: from selection of suitable patients and procedures to determination of appropriate outpatient settings in which to perform the procedures. They also explore perioperative management (that is, premedication, anesthesia, monitoring, and immediate postoperative care), as well as discharge and postoperative pain control. For example, when assessing a patient's suitability the authors recommend that the following six questions be asked:

1. Is the facility adequately equipped and appropriate for the intended procedure, and are quality standards maintained?
2. Can the procedure routinely be performed safely without hospital admission?
3. Is the patient at risk for major complications if the operation is performed in the facility?
4. Do concomitant or comorbid conditions present unnecessary risks in the intended setting?
5. Will the patient require any special instructions or emotional counseling before the operation?
6. Do the patient and the family understand their own obligations regarding postoperative care in an outpatient setting?

Subscribers may view the full text of "Outpatient Surgery" at *www.acssurgery.com*.

V. Operative Management

7. Open Esophageal Procedures. John Yee, MD, and Richard J. Finley, MD, FACS. As Drs. Yee and Finley discuss in their introduction, operative

Online discount

As a special member benefit for ACS Fellows, Associates, and Candidates who are not already subscribers to the College-sponsored *ACS Surgery: Principles and Practice,* we are pleased to offer a $20 discount on subscriptions to the online version of the reference. You pay an annual subscription fee of $179, instead of the customary $199 rate. Please go to *www.acssurgery.com/learnmore.htm* for more information and to save $20 on the online version.

Subscribers to the print and CD-ROM versions of *ACS Surgery* continue to receive free online access to the monthly updates and full text by visiting *www.acssurgery.com*. You will need your nine-digit account number, which may be obtained by calling 800/545-0554 or 914/962-4559 (outside the U.S.), by faxing 914/962-5076, or by e-mailing acssurgery@webmd.net. Updates also are available quarterly through subscription to the *ACS Surgery* CD, which incorporates every online update from the previous three months, and yearly through subscription to the annual hardcover edition of *ACS Surgery,* which incorporates every online update from the preceding year.

techniques for treating esophageal disease have advanced considerably in recent years as a result of improved understanding of esophageal anatomy and physiology and the successful introduction of minimally invasive approaches to the esophagus. (See *V.8, Minimally Invasive Esophageal Procedures* in the June 2002 *Bulletin*). For a number of diseases, such as achalasia, minimally invasive procedures have proven to be as effective as their open counterparts while causing less postoperative morbidity. Nevertheless, the growing stature of minimally invasive approaches does not diminish the importance of the equivalent open approaches.

In their new chapter, Drs. Yee and Finley describe common open operations performed to excise Zenker's diverticulum, to manage complex GERD, and to resect esophageal and proximal gastric tumors. Included are the following:

- Cricopharyngeal myotomy and excision of Zenker's diverticulum.
- Transthoracic hiatal hernia repair.
- Transhiatal esophagectomy.
- Ivor-Lewis esophagectomy.
- Left thoracoabdominal esophagogastrectomy.
- Postoperative care, complications, and outcome evaluation of esophagectomy. Subscribers may view the full text of "Open Esophageal Procedures" at *www.acssurgery.com*.

VI. Operative Management

Anal Procedures. Ira J. Kodner, MD, FACS. In recent years, the frequency of hemorrhoid surgery has diminished significantly. More patients seem to be achieving adequate symptomatic relief by means of bowel control medications and improved diet (that is, increased intake of fiber, fruit, vegetables, and grain). These trends, combined with the availability of more and better patient information, probably explain why fewer patients today have hemorrhoids that progress to a stage advanced enough to necessitate operative treatment for relief of symptoms.

In this chapter, Dr. Kodner reviews the operative management, techniques, complications, and outcomes for hemorrhoids, abscess and fistula, and ulcer/fissure disease. Subscribers may view the full text of "Anal Procedures" at *www.acssurgery.com*.

Looking ahead

New and revised chapters scheduled to appear as online updates to *ACS Surgery: Principles and Practice* in 2002 include the following:

- "Emergency Department Evaluation of the Patient with Multiple Injuries," by Felix Battistella, MD, FACS.
- "Thoracoscopy," by Valerie W. Rusch, MD, FACS, and Raja Flores, MD.
- "Multiple Organ Dysfunction Syndrome," by John C. Marshall, MD, FACS.
- "Biliary Tract Procedures," by Bernard Langer, MD, FACS, and Bryce R. Taylor, MD, FACS.
- "Liver Resections," by Yuman Fong, MD, FACS.
- "Laparoscopic Cholecystectomy," by Gerald M. Fried, MD, FACS; Liane Feldman, MD; and Dennis R. Klassen, MD.
- "Organ Procurement," by Charles M. Miller, MD, FACS, and Thomas R. Starzl, MD, FACS.
- "Postoperative Pain," by Henrik Kehlet, MD, PhD. Ω

Mr. Kelly *is editor,* What's New in ACS Surgery: Principles and Practice, *WebMD Reference, New York, NY.*

Socioeconomic tips of the month

Updates on the Medicare program

by the Division of Advocacy and Health Policy

This month's column provides surgeons with an update on recent Medicare program activity.

No summer newsletter

Surgeons may have noticed that they have not received a paper copy of their Part B carrier's newsletter this summer. That is because in May, the Centers for Medicare & Medicaid Services (CMS) mandated that all Medicare Part B carriers eliminate all provider bulletins and newsletters scheduled to mail between July 1, 2002, and September 30, 2002, so that the funds could be used to support implementation of the Health Insurance Portability and Accountability Act (HIPAA). Most Part B carriers will post Medicare updates on their Web sites. The College invites surgeons to visit *http://www.facs.org/dept/hpa/practmanres.html,* which contains links to all Part B carrier Web pages. Practices that do not have Internet access should be sure to check this column next month for Medicare updates.

HCPCS eliminated

Because HIPAA establishes specific national coding systems, Medicare Part B carriers will eliminate unapproved local Health Care Procedure Coding System (HCPCS) (Level III) procedure codes and modifiers effective October 16, 2002. HCPCS Level III codes are W, X, Y, or Z series alpha-numeric codes or modifiers WA through ZZ that are not represented in the HCPCS national Level I or II codes. In most cases, procedures currently reported by local codes can be reported using existing national HCPCS codes and modifiers. If your carrier uses local codes, the College suggests checking recent carrier publications and/or Web sites to get a list of the codes to be eliminated and to update coding software so use of the codes can discontinue by October.

Moving notice

Offices that have relocated recently need to notify their Part B carriers as soon as possible. Beginning October 1, 2002, carriers will begin using "return service requested" envelopes for remittance advice. CMS has instructed carriers to eliminate the forwarding of Medicare remittance advice to any location other than those indicated in their records. If the post office returns an undeliverable envelope to your carrier, the carrier will stop issuing checks and remittance advice to you until they receive a change of address notification in writing. To view the Medicare carrier program memorandum regarding this issue, go to *http://www.hcfa.gov/pubforms/transmit/B02023.pdf.*

Around the corner

September

- Postgraduate course on coding, compliance, and reimbursement presented by the ACS during the Society of Laparoendoscopic Surgeons' Eleventh International Congress and ENDO EXPO on September 11, 2002, in New York, NY. Contact Flor Tilden at 305/665-9959 for registration form.
- ACS-sponsored practice management course for surgeons on September 21, 2002, in Miami, FL. Visit the ACS Web site at *http://www.facs.org/dept/hpa/index.html* to register.

October

- 2003 ICD-9-CM code changes effective October 1. The 90-day implementation period during which Medicare will allow claims to be submitted with the 2002 and the 2003 ICD-9-CM code versions begins.
- Quarterly update to 2002 Medicare fee schedule effective October 1.
- Quarterly update to 2002 Correct Coding Edits effective October 1.
- ACS-sponsored basic coding workshop for surgeons on October 8, during ACS Clinical Congress in San Francisco, CA. To register for PG25, go to *http://www.facs.org/clincon2002/index.html.*

Enrollment applications online

Surgeons who would like to enroll in the Medicare program can now download the Medicare Provider/Supplier Enrollment application from the CMS Web site at *http://www.hcfa.gov/medicare/enrollment/forms*. The application that surgeons should complete is Form CMS 855I for "Individual Health Care Practitioners." It is available either in an electronic version (Formatta Filler 6.0) or as an Adobe Acrobat (*.pdf) file. To download and use the electronic forms, you must have a Windows 95 (or higher) operating system, access to the Internet, an Internet browser, and a printer. It is also advisable to download the "Full Version Users Guide" that contains step-by-step instructions to install the software and to complete the application. Practices that download the electronic version should indicate "Yes" when prompted to "Create shortcut on desktop" during installation of the software; otherwise, problems may arise when opening the document. Using the electronic version, you will be able to complete your application on your computer, save it as a file, and print the completed form for final signature and submission by mail to your Part B carrier. Ω

Correction

In the April 2002 issue of this column, we provided an inaccurate response to a coding question about reporting code 44005, the lysis of extensive adhesions during a hernia repair. The correct coding advice is:

> CPT Code 44005 is defined as a separate procedure and is considered an integral part of many procedures, including hernia repair. If the surgeon performs both the hernia repair and extensive lysis of adhesions, use the -22 modifier on the hernia repair code.
>
> Keep in mind that the use of the –22 modifier requires an operative dictation showing the added work and diagnoses, and a special report explaining the additional diagnoses and how the work involved in the procedure had added difficulty. Modifier –22 should only be reported if the entire procedure took an additional 50 percent longer to complete than a typical hernia repair.

College news

Surgeons gain strength within AMA leadership

The annual meeting of the American Medical Association (AMA)'s House of Delegates (HOD) took place June 15-20 in Chicago, IL. Delegates acted on more than 224 resolutions, including one that the College sponsored, and 87 reports from various AMA Councils and the Board of Trustees.

In addition, a number of surgeons were successful in their bids for AMA positions: Donald Palmisano, MD, FACS, was elected president-elect; William Plested, MD, FACS, was re-elected to the AMA Board of Trustees; and new trustees include Peter Carmel, MD, and John Armstrong, MD, FACS (young physicians trustee to the board). Surgeons now represent at least 30 percent of the AMA board of trustees and almost 22 percent of leadership of AMA councils and sections.

The American College of Surgeons-sponsored resolution that the delegates unanimously adopted concerns payment for sonography. The resolution addresses concerns of numerous surgical specialists that some insurers will not pay them for reading diagnostic sonography. The AMA agreed to work with specialty societies to vigorously advocate with Medicare and other payors that all appropriately trained physicians, regardless of specialty, be reimbursed for performing diagnostic sonography with appropriate documentation (including sonographically directed biopsy, aspiration, and so on) in situations with defined clinical indications.

The House focused much of its attention on the current professional liability crisis and heard from physicians who are experiencing extreme premium increases or are having problems accessing professional liability insurance at all. The House of Delegates determined that medical liability reform is the top advocacy priority for the AMA.

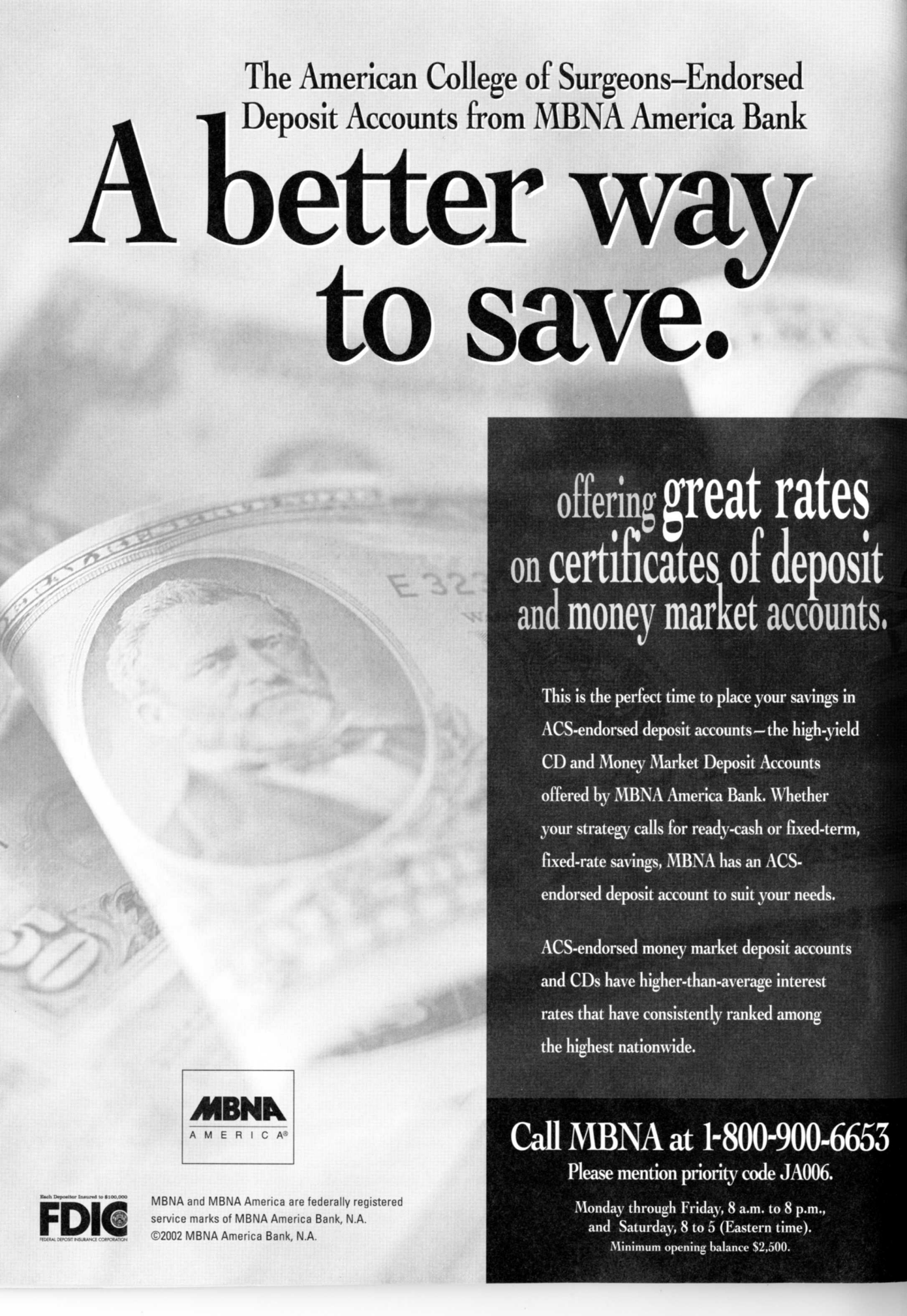
The status of resident work hours was another prominent issue at the meeting. Final recommendations from the AMA Council on Medical Education report were adopted. That report included support for total duty hours not to exceed 80 hours per week (averaged over a two-week period) with the possibility of a 5 percent increase if appropriate for some training programs. The report also suggests that on-call assignments not exceed 24 hours and that on-call not be more frequent than every third night with at least one consecutive 24-hour duty free period every seven days. (Both are averaged over a two-week period). Finally, the AMA agreed to encourage the Accreditation Council for Graduate Medical Education to enforce the resident duty hours common accreditation standards adopted by their Board of Directors on June 11, 2002.

College delegates include the following surgeons: LaMar McGinnis, MD, FACS (delegation chair); Paul Collicott, MD, FACS (alternate delegate); Charles Logan, MD, FACS (alternate delegate); Richard Reiling, MD, FACS (delegate); Amilu Rothhammer, MD, FACS (delegate); Thomas Russell, MD, FACS (alternate delegate); Thomas Whalen, MD, FACS (delegate); and Chad Rubin, MD, FACS (young physicians section delegate).

Fellows who have questions about issues addressed by the AMA House of Delegates should contact Jon Sutton, State Affairs Associate in the Division of Advocacy and Health Policy, at *jsutton@facs.org*.

Update your Fellowship contact information online

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ACS presents first combined meeting of chapter leaders and young surgeons

by Stephen J. Regnier, Editor, and Diane S. Schneidman, Senior Editor

The first combined ACS Chapter Leadership Conference and Young Surgeons Representatives Annual Meeting took place May 15-18, 2002, at the College's headquarters and the Wyndham Hotel in Chicago, IL. The program focused largely on encouraging young surgeon participation in the College and its chapters. In all, 87 chapter officers, young surgeons, and chapter administrators representing 41 chapters attended the meeting.

Session for administrators

Ushering in the program was a half-day meeting for chapter administrators, which included an update on legal issues by Paula Cozzi Goedert, JD, of the law firm Jenner and Block in Chicago, IL. Ms. Goedert shared her legal expertise with the other meeting participants the following day as well.

The chapter administrators' meeting also included a discussion about forming alliances and coalitions with medical and specialty societies for effective political advocacy. The following individuals provided their perspectives:

- Cynthia A. Brown, Director of the College's Division of Advocacy and Health Policy, explained how the College works with coalitions to move its political agenda at the federal level and discussed the College's plans to gain influence at the state level.
- Wanda Johnson, Executive Director of the Tennessee Chapter, provided details about an alliance between a coalition of specialty societies and the Tennessee Medical Association.
- Heather Bennett, JD, Executive Director of the New York Chapter, shared her experience in opening a lobbying firm that represents various groups in that state.
- Robert Harvey, Executive Director of the Florida Chapter, focused on how that chapter has reached out to an array of organizations to promote its mission.

Dr. Russell extends welcome

The full program for chapter leaders and young surgeon representatives began the following day with welcoming remarks by ACS Executive Director Thomas R. Russell, MD, FACS. Dr. Russell said that the joint program was conceived in recognition of the fact that chapter leaders want to attract young surgeon representatives and address their needs so that their chapters will remain vibrant. This combined meeting would give the two groups an opportunity to share their views.

In addition, Dr. Russell provided an update on the College's strategic planning initiative. He noted that the College has restructured to focus its activities and goals on four main areas of interest: Advocacy and Health Policy, Education, Member Services, and Research and Optimal Care. As a next step in the reorganization process, Dr. Russell said, a committee is examining the structure and operations of the ACS Board of Regents, the College's governing body.

Dr. Russell also said that the College strives to improve the future of its chapters. "Our goal would be to help all the chapters," he said. Dr. Russell noted that the chapters are integral to the College's operations in several ways. First, the chapters have the ability to consolidate their efforts with the regional specialties. This outreach ability, he said, "makes the College a little smaller—breaks it down."

The chapters also can play a key role in influencing medical and surgical students and offer educational programs that are specific to the needs of local surgeons. Because health policy often is made at the state level, the chapters can be instrumental in the political process, Dr. Russell said. Finally, he said, the chapters have the potential to help the College to screen out weak applicants for Fellowship by increasing their interaction with their local committees on applicants.

Mentoring

Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the College's Division of Education, spoke about how the College and its chapters could use the mentoring process to encourage young surgeons. Dr. Sachdeva noted that these relationships are long-term and both personal and professional. In these relationships, the mentor works one-on-one with the protégé and should be respected within his or her field. Both the protégé and the mentor "reap significant rewards and both are transformed in the process," he said.

Dr. Sachdeva explained that the mentoring process involves four stages:

1. *Initiation:* At this time, the mentor and protege get acquainted.
2. *Cultivation:* This is the phase when the two are actually working together to grow and learn.
3. *Separation:* "Probably the most difficult stage," he said. This is when the mentor leaves the protégé on his or her own to become more independent.
4. *Redefinition*. This is the point at which the two people view each other as peers and develop a lasting relationship.

Chapters and the College need to encourage their prominent members to volunteer to serve as mentors to the young surgeons in their area, so that they will continue their commitment to the profession and develop an interest in the ACS and its chapters, Dr. Sachdeva said. The College, he added, could serve as the central organizing body for this endeavor.

Strategic planning

Jim DeLizia, principal of DeLizia Consulting Services, led a highly interactive session demonstrating effective techniques for strategic planning. Strategic planning involves three phases, according to Mr. DeLizia. The first step is articulating a direction. At this stage, an organization should consider its purpose and overarching objectives with the goal of generating a mission statement that outlines the organization's vision.

In step two, Mr. DeLizia said, an organization should capture its priorities based on its membership and current structure, changes that need to be made, and short- and long-term goals. Finally, an organization should start taking action, he said. It should develop strategies for reaching each milestone, begin implementing the plan, and monitor and measure its success in carrying out the plan.

In addition, Mr. DeLizia described the qualities of strategic planning. He said the planning process itself has the following characteristics: (1) encourages free and open exploration of ideas; (2) drives toward consensus and sets targets focused on change; (3) includes all perspectives that will allow the organization to better meet the needs of its members; (4) involves all major leaders and stakeholders; (5) develops and uses data to arrive at informed decisions; and (6) fits the organization's needs and ideals.

Presidential address

The second full day of activities began with welcoming remarks from R. Scott Jones, MD, FACS, President of the College. Sounding a note of optimism about the future of surgery, Dr. Jones said, "I would like to be a young surgeon today…because I believe the future of this enterprise is better than ever." He noted that the surgeons attending the meeting could now "do more things, cure more diseases, save more lives" than ever before. He noted that when he first entered surgery, transplants, open-heart surgery, ventilators, intensive care units, and so on did not exist.

Advances in medicine and surgery are expected to occur even more rapidly over the coming years, he added. "For me, that's an upper," Dr. Jones said. When young surgeons reach a more advanced stage of their careers, "You're going to say, "I remember back at the turn of the century, we actually had to make an incision to do an operation'" or that certain types of cancer were incurable, he added.

Some of these changes will likely stir up conflict and tension, Dr. Jones said. The way to resolve conflict "is by sticking with our core values," he added. These core values include the profession's "commitment to patients, to saving lives, to improving the quality of living, and to improving the quality of dying," he noted.

Executive staff reports

The College's executive staff outlined the changes that are occurring within the organization. Highlights of their presentations were as follows:

• Ms. Brown noted that the College recently established a new 501(c)(6) organization known as the American College of Surgeons Professional Association (ACSPA). ACSPA will make it possible for the College to increase its lobbying efforts and to establish a political action committee. She encouraged attendees to become involved in the College's political efforts, noting that "we are as strong as our membership. You're our early warning system as well as our reality check."

• Dr. Sachdeva noted that efforts are under way to enhance programming for the Clinical Congress and the Spring Meeting and to update the Surgical Education and Self-Assessment Program (SESAP) 12. Among other plans, the College intends to launch a new national mentoring program and build a more comprehensive video library.

Further, Dr. Sachedva noted that the College has applied for continued funding from the Agency for Healthcare Research and Quality for the program "Educating Surgeons in Patient Safety."

• Paul E. Collicott, MD, FACS, Director of the Division of Member Services, reported that more than 64,000 surgeons currently are members of the College. Of them, approximately 50,000 are active Fellows. More than 60 percent of the Fellows are in specialties other than general surgery, and only about 60 percent of board-certified general surgeons are Fellows, he added.

• David P. Winchester, MD, FACS, provided attendees with an overview of the purpose and structure of the Commission on Cancer (COC).

The COC is a consortium of about 40 national professional organizations that deal with cancer care and comprises three standing committees: the Committee on Approvals, the Committee on Cancer Liaison, and the Committee on Education. In addition, the COC has 12 disease site teams, Dr. Winchester said.

• Linn Meyer, Director of Communications, said that her area is responsible for the College's public information activities, for most of its print and electronic publishing efforts, and for general liaison functions with the public, the Fellows, and the media.

Additionally, Communications is working to expand the College's promotional and marketing activities, Ms. Meyer said.

• Howard Tanzman, Director of Information Services, discussed how chapter leaders can make the best use of the College's Web site and links.

• Fred Holzrichter, Manager of the Development Program, noted that the College has received gifts totaling more than $17.9 million to fund the ACS development program, which supports surgical education and research. Additionally, he said that 500 individuals are currently members of the Fellows Leadership Society, meaning that they contributed $1,000 or more to the program in the last year.

• Alden Harken, MD, FACS, Interim Director of the Division of Optimal Care and Research, provided an update on the College's participation in the Patient Safety in Surgery study with the Veterans Administration (VA). The study is designed to evaluate the effectiveness of the VA's National Surgical Quality Improvement Program as a patient safety reporting system.

Bioterrorism preparation

The U.S. trauma system is designed to appropriately respond to casualties associated with civilian injuries and conventional warfare, according to David B. Hoyt, MD, FACS, Medical Director of Trauma at the College. The increasing use of unconventional weaponry and the threat of bioterrorism demand new response systems, he said. The types of trauma with which Americans have become familiar and the types that result from terrorist activity differ in terms of the magnitude or type of injuries, the number of casualties, and the risks to physicians and other providers of care, Dr. Hoyt said.

In order to better deal with the probability of future terrorist actions, Dr. Hoyt suggested that surgeons and other health care leaders should: (1) understand their local emergency medical system (EMS); (2) participate in the local EMS plan; (3) know and understand the National Disaster Medical System; (4) increase their own knowledge about terrorism and its potential effects; (5) and help to educate other providers and the public.

Membership issues

"When we look at membership, we need to view it from the perspective of the grassroots member and member-to-be," according to John H. Armstrong, MD, FACS, who serves on the American Medical Association's Advisory Committee on Membership. In other words, organizations need to look at how well they are fulfilling the needs of their current members and whether they will be able to meet the expectations of potential recruits.

First, organizations need to consider generational differences, Dr. Armstrong said. Members of the World War II generation are joiners. They appreciate the sense of community spirit that professional organizations offer. Baby Boomers and particularly Generation Xers prefer to be "free agents," he said. Dr. Armstrong said that the existing model that many organizations follow does not resonate with younger people, who prefer to relinquish their limited free time only to those groups that they believe provide the highest quality of service and that will not make high demands on their time and money.

To encourage young surgeon involvement, Dr. Armstrong suggested replacing standing committees with ad hoc projects, so that participants feel less pressure to make long-term commitments. He also recommended limiting the length and number of meetings. Additionally, Dr. Armstrong said organizations should "stop doing things that don't matter to members," and adapt to the customer. The mantra for organizations that are trying to boost their membership through young member involvement should be "embrace and serve, recruit and retain," he added.

Concurrent sessions

The conclusion of the Chapter Leadership Conference segment of the program featured three concurrent workshops: Planning Educational Programs to Meet Members' Needs, Membership Communications, and Make Your Mark and Make It Count: Tools of the Trade for Effective Federal and State Advocacy.

The first workshop focused on how chapters can develop educational programs that satisfy the needs of all current and potential members, from residents to established practicing surgeons. Mary E. Maniscalco-Theberge, MD, FACS, Vice-President of the Metropolitan Washington Chapter, explained how that chapter has continually developed a range of educational programs. Charles F. Rinker II, MD, FACS, Past-President of the Montana-Wyoming Chapter, discussed strategies for stimulating an interest in surgery among young people.

The session on membership communications included presentations by Ms. Meyer, Mr. Tanzman, and Sally Garneski, Manager of Public Information for the College. They discussed communications strategies and processes, including the use of newsletters, e-mail, Web sites, and so on, as well as the communications services available through the College.

Participants in the session on advocacy learned about real-life strategies for federal and state advocacy. Kristen A. Zarfos, MD, FACS, President-Elect, Connecticut Chapter, discussed her efforts to secure passage of federal legislation that curbed "drive-thru mastectomies." Adrienne A. Roberts, Government Affairs Associate, and Jon Sutton, State Affairs Associate, both of the College's Division of Advocacy and Health Policy, provided an overview of the federal and state legislative processes. Shalla M. Ross, staff to the U.S. House Committee on Ways and Means, offered advice for effective lobbying.

Young surgeons

The third full day of activities featured three sessions directed specifically toward the young surgeon and his or her practice. Gary L. Timmerman, MD, FACS, Vice-Chair of the Committee on Young Surgeons, began the session by welcoming attendees and introducing Dr. Russell.

Dr. Russell told the attendees that the nature of surgery is rapidly changing and must be more diverse and flexible to attract qualified medical students in the future. "The notion of giving 100 percent of your time to building a surgical practice is acceptable to some medical students, not acceptable to others," Dr. Russell said. Through the work of the ACS chapters and the Committee on Young Surgeons, Dr. Russell said, the College hopes to become more diverse in scope and make the entire spectrum of surgery attractive to a broader range of medical students. He urged young surgeons to become involved in

research and advocacy. "The practice of surgery will most certainly change in the coming years, and we as an organization and profession must change to meet the growing needs of our members," Dr. Russell said.

The first speaker was J. Robin Wright, president of Wright Communications. Ms. Wright discussed communications strategies for surgeons and their staffs. She outlined a research-based approach to building trust and credibility with patients, reassuring patients of surgical safety, and presenting surgical risks with clarity and confidence.

Ms. Wright stated that the perception of "surgical risk" is different for each person, and that surgeons should first and foremost seek to establish trust with their patients. She said that there are four primary components of trust: competence/expertise, caring/empathy, honesty/openness, and dedication/commitment. To successfully communicate with patients about surgical risks, surgeons must strive to develop skills in these primary areas.

According to Ms. Wright, patients experiencing good communication with their physician have less anxiety, experience less discomfort postoperatively, require less medication, recuperate more quickly, remember/follow postoperative instructions better, are more likely to refer other patients, and are less likely to sue.

The second speaker was Erle E. Peacock, Jr., MD, JD, FACS, who spoke on how to be an *expert* expert witness. Dr. Peacock discussed the three types of expert witness: the defendant expert witness, a treating physician expert witness, and an expert witness who is called to assist the trier of fact. Direct examination of all three types of expert witness is usually routine, and most lawyers do a good job of preparing physicians adequately, he said.

Dr. Peacock discussed common reactions among physicians when facing malpractice litigation, including humiliation, denial, anger, vengeance, and despair. "Physicians *must* overcome these feelings before they can be a good expert witness," he said.

With regard to the deposition phase for the defense expert witness, Dr. Peacock offered the following advice:

1. Do not try to plead your case—you can never win. Answer simply "yes" or "no."
2. Never volunteer any information and never speculate.
3. Avoid answering too quickly—a slow and reasoned response is better.
4. Be aware of questions that make you look good.
5. Do not become tired, but remain in control.
6. *Never* say "I would have done it differently."

Dr. Peacock concluded with cogent advice for expert witnesses at trial, the process of jury selection, and the importance of staying power over the course of a long trial. "Remember that the trial begins the second you as an expert witness enter the courtroom, and your demeanor and testimony must appear neutral and objective to be truly effective," Dr. Peacock said.

The final speaker was Frank G. Opelka, MD, FACS, chief of the division of colon and rectal surgery and vice-chief of finance for the department of surgery, Beth Israel Deaconess Medical Center/Harvard Medical School, Boston, MA.

Dr. Opelka discussed the financial analysis and management of a surgical practice. He presented a basic primer in practice management and offered insights into key components of office management, surgical office business plans, payor compliance, and contract analysis.

Dr. Opelka told the young surgeons that it was essential for them to pay attention to the "details" of their practices. An effective business system is an integral component of an effective surgical practice. Office management must provide open, transparent monthly reviews of key indicators in a surgical practice, Dr. Opelka said.

According to Dr. Opelka, fundamental monthly/annual financial reports should include information needed to analyze the budget process, medical practice statistics reporting, a balance sheet, and an income sheet.

"Good reports lead to good management—the two are connected. And being fiscally responsible is being socially responsible, both to your practice and to your community," Dr. Opelka concluded.

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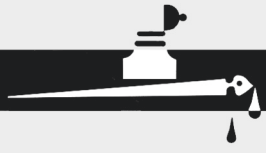
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Letters

The following comments were received in the mail or via e-mail regarding recent articles published in the Bulletin *and the "From my perspective" columns written by ACS Executive Director Thomas R. Russell, MD, FACS.*

9/11/01

I read with renewed pain and anguish the feature article in the May *Bulletin* on September 11, 2001. On that fateful day, I saw from a distance the collapse of one of the World Trade Center (WTC) towers and headed for the operating room to offer my services to the staff that had already been mobilized. We were all frustrated and disheartened to learn that there were fewer survivors than dead victims, and our resources were not tested.

The article reports that in the initial WTC bombing, 160 patients were treated and 40 admitted. In the more recent event, 797 were treated and 115 admitted. Had 50 percent of the dead victims been seriously injured survivors, would the transportation and hospitalization resources of an island with many hospitals and medical schools been sufficient?

It was reassuring to learn that Mayor Giuliani provided a water supply, but is there a provision for this solution in any hospital disaster plan?

The transfer of the most seriously burned patients to a burn center at another site reflects collegial cooperation and is to be lauded, but suppose the secondary institution had been overwhelmed with such cases or transportation was ineffective. What then? And consider the role of earlier triage to make the referral directly.

I have visited the Ground Zero clean-up, and the emptiness of the air space that used to hold the buildings and the people is a painful memory burned into me.

This type of tragedy and worse may befall us. The various agencies of government with complicated and sometimes political agendas are considering and planning our future responses. This may be a time for the American College of Surgeons to create guidelines and communication channels for the hospitals and physicians who will be responding to the next attack, both here in New York and elsewhere.

Robert C. Wallach, MD, FACS

Surgical training

It was with great interest that I read Dr. William Scurlock's article in the May 2002 issue. After graduation from LSU School of Medicine-New Orleans in 1961, I did a rotating internship at then-Confederate Memorial Medical Center (CMMC) in Shreveport, LA. Dr. Scurlock was a surgical resident at the time.

I must take issue with some of the ideas expressed in his article, though.

He was correct in saying that the surgical training at CMMC was the "see one, do one, teach one" method as there was little, if any, supervision of the surgical residents by the visiting staff. This was the method used at Charity Hospital in New Orleans as well as at other institutions around the country. This method was fun for the residents but also meant that, if a mistake crept into the system, it was perpetuated from one resident to the next. I traded that method of teaching for the one used at the Mayo Clinic and found my surgical education much the better for it. Although my actual operating time was reduced, the foundations in surgery that I received from some of the very best surgeons of the day could not have been better. I never had problems in the operating room with my technical skills.

I feel sorry for Dr. Scurlock and for his patients and for his family if he truly felt that "at no time did I feel free of call" although having very capable partners. Patients easily understand the need for their physician to have some time off and do not begrudge it at all.

I was also dismayed to see that he felt he was capable of operating "around the clock" and performing up to par the following day. This belief is truly a myth that needs to be buried as quickly as possible! We know much more today about the effects of fatigue on job performance and it is this knowledge that has led to work restrictions upon those persons operating airliners and trains. There is no physician who would knowingly board a plane or train operated by an exhausted crew; why should we subject our patients to such a risk?

I, too, loved being in the operating room. During cases in which everything was going well and I had a "crew" I truly liked and respected, I would think that it was almost a sin to be paid for something that was so much fun. The day it was no longer fun was the day I decided to change careers and then prepared myself to do so. I am now involved in administration of a freestanding hospital and find the work challenging in a completely different way.

George R. Smith, MD, FACS

Global surgical services

"From my perspective" of June 2002 raises critical issues that are not only related to retention of reimbursement quanta. Dr. Russell refers to that issue in terms of "...surgeons cannot be barred from having access to their patients in the intensive care unit...." An Australian surgical perspective may be of interest.

In the last few decades, surgeons' autonomy has been seriously and progressively eroded by the ambitions and involvement of nonsurgeons who are reimbursed separately for procedures in operating rooms and in critical care areas, sometimes regardless of the surgeons' wishes.

Many of those procedures are undertaken not by "delegation" but by virtue of assumptions promoted by the existence of fee schedules that may undo the "bundle" traditionally regarded as the inevitable and appropriate responsibility of a surgeon. After all, most patients do recognize the surgeon as their only long-term attendant whom they expect to supervise all management and, above all, be primarily responsible for outcomes.

Therein lies another powerful reason why surgeons must "direct" all of perioperative management. Being "captain of the ship" in the eyes of litigants and courts demands that surgeons are not implicated in untoward, or even toward, events over which they may have had no control or even awareness.

John Wright, MD, FACS

Health care worker shortage

I read with interest the articles in the June *Bulletin* concerning the health care worker shortage. And, ironically, when I got to page 33, I discovered another factor that is causing the health care worker shortage. For years now, I have said that the incursion of the four M's (Medicare, Medicaid, managed care, malpractice) was going to be the downfall of American medicine. Now I can add a fifth—risk management. It may be that at some point it may take longer to get the informed consent form signed than it does to do the operation.

William E. Weldon, MD, FACS

Provider volume

The excellent article by Drs. Lee and Daly in the June *Bulletin* gives us a glimpse of the future that could be a win-win situation for surgeons and patients. A well-designed report card that evaluated surgeons and institutions would not only benefit patients. Excellent surgeons and their teams could serve as mentors to upgrade other surgical programs to get the best results for various procedures.

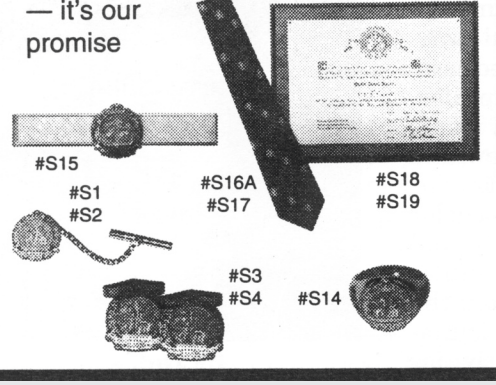
As new technological procedures with steep learning curves arise, patients and surgeons would both gain from identifying centers of excellence and establishing mentors for each procedure on a broad nationwide scale. Programs that did not meet a satisfactory level of performance in a reasonable period of time would benefit patient care by dropping the procedure.

Jerry Frankel, MD, FACS

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After Clinical Congress, Syllabi Select will be available by calling 312/202-5474 or through the College's Web site at *http://secure.telusys.net/commerce/current.html*

The 2002 Syllabi Select CD-ROM is priced at $75. There is an additional $12 shipping and handling charge for international orders.

SYLLABI SELECT

PG 15: Endocrine Surgery

PG 16: Diseases of the Liver, Biliary Tract, and Pancreas

PG 17: Vascular Surgery: Technical Tips That Enhance Surgical and Endovascular Outcomes

PG 18: Thoracic Surgery

PG 19: Gastrointestinal Disease

PG 20: Minimal Access Surgery

PG 21: Essential Technical Elements in Trauma

PG 22: Cardiac Surgery

PG 24: Colon and Rectal Surgery

PG 26: Surgical Infection and Antibiotics

PG 27: Breast Disease

PG 28: Plastic Surgery: Management of Devastating Defects of the Abdomen and Perineum

PG 29: Pediatric Surgery: Esophageal Disorders and Anomalies in Infancy and Childhood

PG 30: A Surgeon's Personal Guide to Risk Management and Trial Participation

AMERICAN COLLEGE OF SURGEONS • DIVISION OF EDUCATION

Chapter news

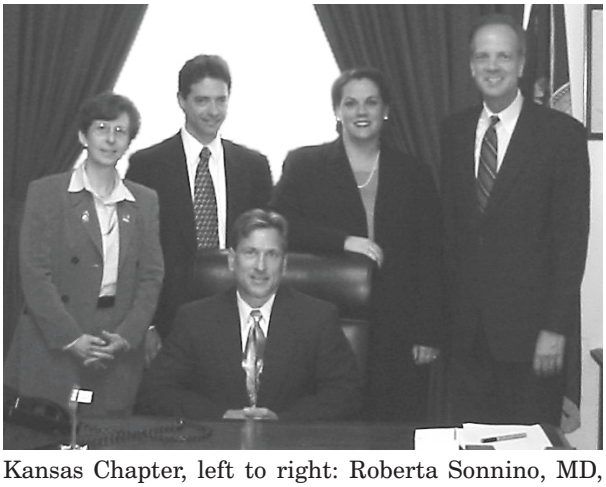
by Rhonda Peebles, Chapter Services Manager, Division of Member Services

To report your chapter's news or to share photos of your chapter's events, contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at rpeebles@facs.org.

Chapters visit Capitol Hill

On April 23, the **Kansas Chapter** conducted its annual visit to Capitol Hill in Washington, DC (see photo, top right). Other chapters that have completed visits this year include Florida, Kentucky, Brooklyn-Long Island (NY), and Tennessee. In addition, 10 other chapters have visits scheduled: Connecticut, Georgia, Metropolitan Chicago, Maryland, New Hampshire, New Jersey, Southwest Pennsylvania, North Texas, Virginia, and Wisconsin.

To schedule a Capitol Hill Visit for your chapter in 2003, contact Chris Gallagher at 202/337-2701, or at cgallagher@facs.org.

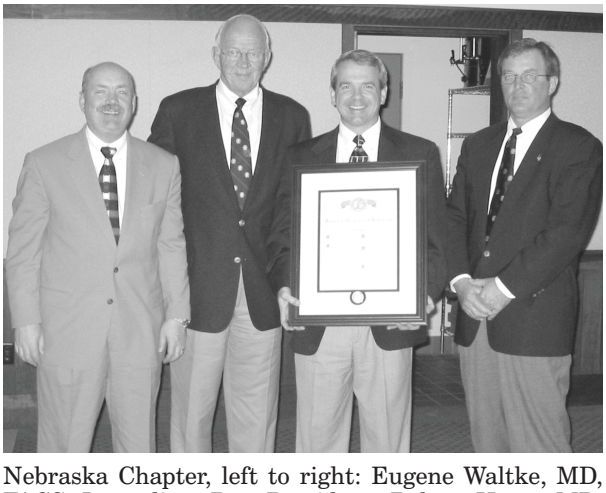


Kansas Chapter, left to right: Roberta Sonnino, MD, FACS, council member; Jonathan Dort, MD, FACS, council member; Joe Bosiljevac, MD, FACS, President (seated); Adrienne Roberts, ACS Washington Office; and U.S. Rep. Jerry Moran (R-KS).

50th anniversaries observed

The **Nebraska Chapter** observed its 50th anniversary May 10-11, at the Lied Conference Center in Nebraska City, NE. John T. Preskitt, Sr., MD, FACS, ACS Regent, presented the special commemorative charter to the Chapter's officers (see photo, bottom right). In addition to this special event, Robert Condon, MD, FACS, served as the visiting professor and as the moderator for "Surgical Jeopardy," an education program for residents at University of Nebraska Medical Center and Creighton University.

In addition, on May 2-3, the **Indiana Chapter** observed its 50th anniversary in Indianapolis. During the two-day education program, a number of papers examining the Indiana trauma system were presented, and a residents' paper competition was conducted. In addition, James Madura, MD, FACS, Governor, presented a report on a survey of Indiana Fellows. In response to questions about services that the chapter could provide, the following suggestions were reported: (1) communicate information about important issues; (2) lobby the state government to improve reimbursement; (3) place more emphasis on the surgical specialties; (4) provide a forum to publish reports on interesting cases; (5) work more closely with the American Medical Association, Centers for Medicare & Medicaid Services, and so forth to improve advocacy; (6) encourage the in-



Nebraska Chapter, left to right: Eugene Waltke, MD, FACS, Immediate Past-President; Robert Harry, MD, FACS, Governor; Ronald Ernst, MD, FACS, Secretary-Treasurer; and Dr. Preskitt.



Indiana Chapter, left to right: Richard Graffis, MD, FACS, Immediate Past-President; David F. Canal, MD, FACS, President-Elect; Inder K. Seekri, MD, FACS, Secretary-Treasurer; Dr. Madura; Robert E. Pennington, MD, FACS, Governor; and L.R. Scherer III, MD, FACS, President.



Northern California Chapter: Dr. Russell (back row, fourth from right) presented a commemorative charter to the chapter, which recently observed its 50th anniversary. Receiving the charter from Dr. Russell is Robert Mackersie, MD, FACS, Immediate Past-President. Also pictured are chapter council members, officers, and Governors.

volvement of younger surgeons and residents; and (7) conduct seminars on contract negotiations.

J. Patrick O'Leary, MD, FACS, Chair of the College's Board of Governors, served as the distinguished lecturer and presented the 50th anniversary commemorative charter during the chapter's annual business meeting. In addition to these events, a special dinner honoring Jay Grosfeld, MD, FACS, and Dr. Madura was hosted by the Indiana University School of Medicine (see photo, above left).



Dr. Saylor of the South Dakota Chapter.

Also on May 2-3, the **South Dakota Chapter, in conjunction with the North Dakota Chapter,** conducted its 50th annual meeting. The education program featured 17 courses that were applicable to Category 1 continuing medical education credit, and nearly 100 Fellows, Associate Fellows, and Candidates attended. Thomas R. Russell, MD, FACS, the College's Executive Director, presented a commemorative charter to the South Dakota Chapter. In addition, special recognition was extended to Howard L. Saylor, Jr., MD, FACS (see photo, left), who has attended all 50 annual meetings of the chapter. Dr. Saylor became a Fellow in 1951, and he resides in Huron, SD.

Chapters make more use of Web

The Northern California Chapter went online with its Web site last May. The address is: *http://www.facs.org/chapters/northerncalifornia/*. Included on the Web site is a directory of Fellows residing in the Northern California Chapter, a calendar of future events, and past issues of its newsletter.

Also, the Ohio Chapter, the first to go online, has been completely redesigned its Web site. Now, Ohio Fellows may contact their legislators (both federal and state) directly via the Web site and can access information about continuing education programs sponsored by medical schools and specialty societies. Visit the new Web site at *http://www.ohiofacs.org/index.html*.

Currently, 36 chapters have Web sites, including Alberta, Arizona, Northern California, Metropolitan Chicago, Chile, Colorado, Connecticut, Florida, Georgia, India, Indiana, Iowa, Kentucky, Louisiana, Maine, Metropolitan Washington, Mexico (Nor-Occidental), Michigan, Missouri, Ne-

vada, New Hampshire, New York, North Carolina, Ohio, Eastern Pennsylvania, Southwestern Pennsylvania, Puerto Rico, Rhode Island, San Diego, South Dakota, Tennessee, North Texas, Vermont, Virginia, Washington (State), and Wisconsin. To access all the chapter Web sites, go to *http://www.facs.org/about/chapters/chapmenu.html*.

Chapter anniversaries

Month	Chapter	Years
July	**Southwest Missouri**	**50**
	New Jersey	51
	Eastern Pennsylvania	**50**
	West Virginia	52
August	Georgia	52
	Hawaii	51
	Illinois	52
	Brooklyn-Long Island, NY	52
	Northwest Pennsylvania	51
	Rhode Island	**50**

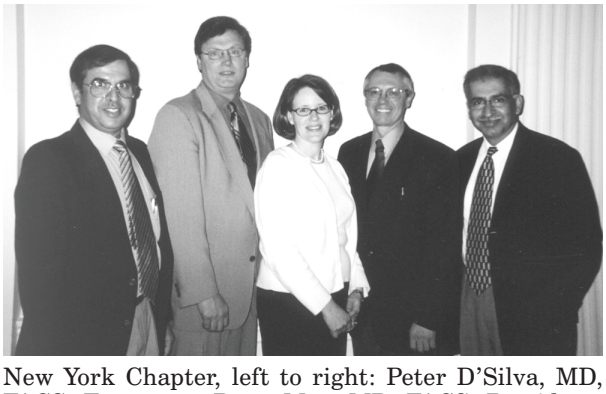
New York and Texas host education programs

The **New York Chapter** hosted its 2002 education program and business meeting April 25-26, in Cooperstown, NY. The education program featured three sessions on breast cancer (sentinel node biopsies, BRCA1/2 testing, and ductal screenings), and the presentation of two winning papers from the residents competition:

Jay Steinberg, DO, SUNY Upstate: "Metalloproteinase Inhibition Improves Survival following Cecal Ligation and Puncture in Rats."

Adil Ceydeli, MD, MS,* New York Methodist Hospital: "Delayed Postoperative Pneumoperitoneum: A Case Report."

During the annual business meeting, new officers were elected (see photo, this page), and the members agreed to conduct the following activities: (1) a New York lobbying day in 2003; (2) work with the New York Bureau of Emergency Medical Services to restore trauma funding; (3) submit resolutions for consideration at the 2003 annual meeting of the Medical Society of the State of NY; and (4) continue to consider establishing a political action committee for New York Fellows.



New York Chapter, left to right: Peter D'Silva, MD, FACS, Treasurer; Peter Max, MD, FACS, President-Elect; Heather Bennett, JD, Executive Director; John Nicholson, MD, FACS, President; and Saqib Chaudhry, MD, FACS, Secretary.

Previously, on February 22-23, the **North Texas Chapter** conducted its forty-first annual CME program. A total of 212 Fellows, as well as 16 residents from four different training programs, registered for the event. The six guest speakers included: Dan Jones, MD, FACS—Bariatric Surgery; G. T. Shires III, MD, FACS—Radio-Frequency Ablation to Treat Liver Tumors; Rebekah Naylor, MD, FACS—Surgery in India; Patricia Numann, MD, FACS—Thyroid Cancer; Leigh Anne Neumayer, MD, FACS—VA Cooperative Trial on Hernia Repair; and Thomas Russell, MD, FACS—ACS Update.

This year's competition featured 18 scientific papers and 14 posters. The winners included:

Best overall paper: A. N. Patel, MD,* Baylor University: "Clinical Benefits of Leukocyte Filtration during Valve Surgery."

Best trauma paper: R. S. Friese, MD,* University of Texas: "The Modified Multiple Organ Dysfunction Score Is a Reliable Indicator of ICU Death after Trauma."

Best oncology paper: J. P. Carroll, MD,* Baylor University: "Long-Term Results for Cryosurgery after Liver Metastasis from Colorectal Cancer."

Best poster: T. O. Moore, MD,* Baylor Univer-

*Denotes Associate Fellow or participant in the Candidate Group.

sity: "Loss of Heterozygosity at 6q22-23.3 in Congenital Nevi, Acquired Nevi, and Cutaneous Melanoma after Laser Capture Microdissection."

Tracking state legislation

The American College of Surgeons has gone "live" on its Web site with a page devoted to state legislative issues. As reported earlier this year, Fellows and College chapters can keep track of proposed state legislation and regulations via this page's database at *http://www.facs.org/dept/hpa/state.html*. The database includes information on dates of a state's legislative sessions, a link to each state legislature's Web site, and bills and regulations of particular interest to surgeons. For more information and/or assistance with this new database, contact Jon Sutton, State Affairs Associate in the Division of Advocacy and Health Policy, at 312/202-5358, or via e-mail at jsutton@facs.org.

The Candidate and Associate Society of the American College of Surgeons (CAS-ACS) invites all residents, residency program directors, and Associate Fellows to attend a symposium on professionalism and how it is taught in the medical environment during the Clinical Congress in San Francisco. The symposium will be held Sunday, October 6, 2002, from 2 to 5 pm.

The speakers will be Ajit K. Sachdeva, MD, FACS, FRCSC, Director of the College's Division of Education, and Michael E. Whitcomb, MD, Senior Vice-President for Medical Education and Director, Division of Medical Education, Association of American Medical Colleges. Dr. Whitcomb is also Editor-in-Chief of *Academic Medicine,* the leading journal devoted to issues relevant to academic medicine. There will be an open-microphone discussion following their presentations.

For more information about this event or the CAS-ACS, contact Peg Haar at the ACS via email at phaar@facs.org or via telephone 312/202-5312.

CAS Symposium

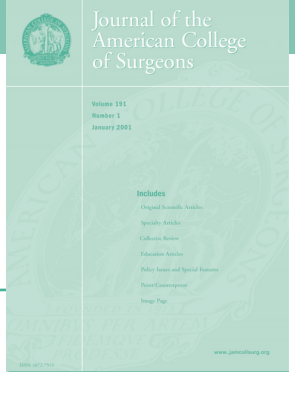
Clinical Congress 2002

Urology review course to be offered during the Clinical Congress

"Urology Review for Recertification Candidates" will be offered as a postgraduate course at the 2002 Clinical Congress in San Francisco. This six-hour course has been developed with leading urologists from across the country and is open to all urologists regardless of membership status within the College. Urologists who are not Fellows who register and pay for this course will have the registration fee for the Clinical Congress waived.

Individuals who take advantage of this educational opportunity will be invited to complete and return the Fellowship application that will be sent to them upon receipt of the course registration form. For further information about the review course, contact Patrice Blair at pblair@facs.org.

Next month in *JACS*



The September issue of the *Journal of the American College of Surgeons* will feature:

Original Scientific Article:

- Bioartificial Liver Support System

Collective Reviews:

- Ablation of Unresectable Liver Metastases
- Theories and Realities of Port-Site Metastases

What's New in Surgery:

- Ophthalmic Surgery
- Endocrine Surgery

Education:

- Advanced Trauma Life Support Skills in Mexico